Maryland Office of Minority Health and Health Disparities

Program Description

VISION

The Maryland Department of Health and Mental Hygiene (DHMH) envisions a state in which health care services are organized and delivered in a manner designed to eliminate health disparities among its ethnic and racial populations, thereby leading the way to a Healthy Maryland in the New Millennium.

MISSION

In fulfillment of the Department's mission to promote the health of all Maryland citizens, the Office of Minority Health and Health Disparities (MHHD) shall focus the Department's resources on eliminating health disparities, partner with statewide organizations in developing policies and implementing programs, and monitor and report the progress to elected officials and the public. The target ethnic/racial groups shall include Hispanic/Latino, Native Americans, Asian and African Americans.

BACKGROUND OVERVIEW

The Maryland 2004 Legislative Session enacted House Bill 86 and Senate Bill 177, officially establishing Maryland's Office of Minority Health and Health Disparities (MHHD), in the Office of the Secretary of the Department of Health and Mental Hygiene effective October 1, 2004. Each bill defines a minority as African-Americans, Hispanics, Asian and Pacific Islanders and American Indians statewide. During Maryland's 2003 Legislative Session, HB 883 paved the foundation for Maryland's Health Care Disparities Initiative that is interwoven within HB 86 and SB177. These bills are codified in the Maryland Annotated Code Health – General § 20-1001, et seq. and § 20-901 et seq.

STATEWIDE PLAN TO ELIMINATE HEALTH DISPARITIES

In December 2006, MHHD released the Preliminary *Maryland Plan to Eliminate Minority Health Disparities*. The plan is available for download at www.mdhealthdisparities.org. MHHD held three annual statewide conferences, convened six town hall meetings in remote areas, held two Native American health round tables and one Latino/Hispanic, Asian American and African American health round table to obtain 1,000 recommendations for the Plan. Next steps for the Plan involve promoting active changes throughout the state within the public and private sectors.

INFORMATION CLEARINGHOUSE

The office has launched and maintains the Department's Health Care Disparities Initiative Website www.mdhealthdisparities.org which contains minority health disparities data both national and statewide, national and Maryland health disparities reports, minority resources, a calendar of minority health events, best practices, health disparities website links, and funding opportunities. The website content can be translated to French, German, Italian, Portuguese, Spanish, Chinese, Korean, and Japanese. The purpose of the website is to provide an information clearinghouse and library for groups interested in minority health issues.

FUNDING OPPORTUNITIES

MHHD searches for funding and resource information for community-based organizations, historically black colleges and universities, as well as DHMH to support opportunities to expand needed services to minority populations and to support community-based programs.

LEGISLATION

MHHD reviews existing laws and regulations to ensure that they facilitate adequate health care for minorities and to recommend changes. In the Maryland 2007 Legislative Session, five bills concerning minority health issues are pending. These bills focus on adult sickle cell disease, racial and ethnic data collection, infant mortality and cultural competency.

DEPARTMENTAL ASSESSMENT

The goal of this initiative is to apply a systems change approach resulting in a greater focus on reducing minority health disparities at the Department of Health and Mental Hygiene. The Secretary has established a Minority Health Disparities Task Force which has designated staff to participate in an internal assessment work group. This work group has completed a pilot testing of the self-assessment instrument. Additionally, MHHD is working with various programs to develop health disparity action plans and to increase the number of disparities reduction objectives in the State Managing for Results (MFR) system. This process will focus on programs addressing the major health disparities areas in Maryland. This initiative is federally funded.

MINORITY HEALTH DISPARITIES DATA

The MHHD Data Program is coordinating a Departmental effort to develop an optimal and standardized approach to racial and ethnic data collection, data analysis, and data reporting. A health disparities data work group has been established and consists of members of administrations throughout DHMH. This work group is involved in developing infrastructure and/or operating procedures to improve the collection, coding, analysis and reporting of racial and ethnic data. This initiative will enhance the Department's ability to track progress in reducing racial and ethnic health disparities. The Data Program also provides data for inclusion on the Health Disparities Initiative website for each of the four minority groups and for women's health issues in Maryland. The program provides technical data assistance to MHHD staff and various DHMH programs, and prepares data sections for grants, reports, data presentations and briefings to various audiences.

WORKFORCE DIVERSITY

The goal of this initiative is to increase minorities in Maryland's health workforce by working with health professional schools to increase the number of minority graduates. This will be accomplished through partnerships with Maryland medical, nursing, dental and pharmacy schools; adaptation of best practices from across the country; implementation of a campaign to increase awareness of the need for greater diversity in the health workforce; collection of baseline and annual data to monitor progress and reinforce best practices that work; and the pursuit of funds to support enhanced recruitment and matriculation of minority students. The initiative also targets increasing the cultural competency of healthcare providers in the state of Maryland by compiling resource listings; identifying best practices and disseminating information pertaining to cultural competency. This initiative is federally funded.

MINORITY OUTREACH & TECHNICAL ASSISTANCE

With passage of SB896/HB1425, the Maryland General Assembly established the Cigarette Restitution Fund Program (CRFP). Minority Outreach and Technical Assistance (MOTA) is a part of the Statewide Public Health component of the CRFP. MOTA focuses on educating, enlightening and empowering ethnic minorities to impact cancer and tobacco health care decisions in their local jurisdictions to eliminate tobacco-related health disparities. MOTA funds community-based, grass-roots, and faith-based organizations to provide outreach services statewide for racial and ethnic minorities and women.

Maryland Office of Minority Health and Health Disparities

ACCOMPLISHMENTS
2006-2007

STATEWIDE PLAN TO ELIMINATE MINORITY HEALTH DISPARITIES

- Completed and released copies of the Preliminary Plan to Eliminate Minority Health Disparities in December 2006. The Plan offered a discussion, with accompanying data, on health disparities in Maryland as well as the nation; its most important feature is a compilation of public comment from over 1,200 citizens
- Held African American and Asian American Health Roundtables in 2006; collected recommendations on reducing health disparities in these populations
- Testified before the House Subcommittee on Health Disparities regarding the Preliminary Plan
- Prepared an Annual Report on HB 883 and HB 86 for the legislature and Administration
- Distributed over 2,000 copies of the Preliminary Plan to community groups, legislators and health advocates

RESOURCE DEVELOPMENT

- In 2006 received renewal of year two of a five-year State Partnership Grant of $787, 750 from the U.S. Department of Health and Human Services, Office of Minority Health. The grant is being used to conduct a self-assessment in the department that will aid in accelerating activities to reduce disparities; and to work with health professional schools to promote diversity in the health workforce

INFORMATION CLEARINGHOUSE

- Updated and maintained a Health Disparities Website (www.mdhealthdisparities.org) that contains health disparities data, racial & ethnic resources, state disparities programs, selected reports and funding opportunities
- Compiled best practices, evidenced-based practices, national and state reports, state minority health plans, national and state minority health data, and ethnic and racial resource directories
- In 2006, the website logged approximately 150,500 hits

DEPARTMENT SELF-ASSESSMENT

- In 2006 the Minority Health Disparities Self Assessment Task Force, chaired by MHHD, met and collaborated with MHHD to develop a health disparities instrument (questionnaire), conducted pilot testing of the instrument, and assembled results
- Consulted with several DHMH divisions on bringing focus to their health disparities related activities and programs and on development of action plans (AIDS Administration, Medicaid, Mental Hygiene, Office of Preparedness and Response, Oral Health, GIS)
- Prepared a Best Practices document for intra-department use, "Best Practices in Capacity Building and Disease Management and Prevention to Address Minority Health Disparities"
- Provided technical assistance to local health departments and hospitals in determining best practices in addressing minority health disparities
- Reviewed the most recent Managing for Results (MFRs) goals and objectives to identify the percent of performance objectives that address health disparities

MINORITY HEALTH DISPARITIES DATA

- Chaired the Health Disparities Data Work Group, providing them with data presentations, discussions of methodological strategies and developing an inventory of data systems within DHMH
- Collected and supplied health disparities data for preparation of the Maryland Plan to Eliminate Minority Health Disparities. Reviewed, edited and corrected all data-related sections for the Plan
- Developed the Maryland Health Disparities Chart Book to include state and local data on minority health disparities trends
- Initiated collaboration with the Maryland Health Care Commission to incorporate information on racial and ethnic differences in annual healthcare quality reports

WORKFORCE DIVERSITY

- Participated in a Statewide Commission on the Shortage in the Healthcare Workforce to bring attention to those workforce shortage issues that impact health workforce diversification
- Planned a panel discussion on workforce diversity to be presented by the three Maryland Schools of Medicine at the upcoming MHHD annual conference
- Provided technical assistance and consultation on cultural competency to local hospitals located in Medically Underserved Areas
- Partnered with Maryland's Health Occupations Boards to promote the awareness of health disparities and to increase the cultural competence of Maryland's health professional licensees

MINORITY OUTREACH AND TECHNICAL ASSISTANCE

- Distributed $1 million of tobacco settlement funds to minority community-based organizations throughout the state to reduce tobacco use and control cancer; grantees worked with local health departments and minority groups to promote awareness, cancer screening, treatment, smoking cessation and prevention; Since 2001, 275 organizations have received funding
- Reached over 85,000 minority persons in 2006 with messages regarding cancer and tobacco-use awareness, education, prevention and screening
- Since 2000, Maryland has significantly increased cancer screening rates, particularly for colorectal cancer, and has reduced the gap between African American and White cancer mortality by 50%.

LEGISLATION AND REGULATIONS

- During Maryland's 2007 legislative session, reviewed 24 proposed bills in both houses, testified 4 times before house and senate committees in hearings in Annapolis, and prepared 7 legislative position papers; submitted 1 letter of information and 2 letters of support as amended; collaborated with other departmental programs to analyze and comment on proposed legislation with impact on minority health
- The Office Minority Health and Health Disparities looks forward to implementing 5 proposed bills that are pending passage. These bills are focused on adult sickle cell disease, racial and ethnic data collection, infant mortality, and cultural competency for mental health professionals

Maryland General Assembly
Legislative Session 2007
Summary of Pending Minority Health Disparities Legislation

SB 269 – Maryland Health Care Commission – Racial and Ethnic Variation Data – Nondiscrimination in Health Insurance

- Requiring the Maryland Health Care Commission to include certain and ethnic variations in certain systems to evaluate the quality of care outcomes and performance measurements of certain health maintenance organization benefit plans, nursing facilities, hospitals, and ambulatory surgical facilities; prohibiting the use of certain racial and ethnic variations information to deny or otherwise affect a health insurance policy or contract; providing that the provisions of certain insurance laws apply to health maintenance organizations; and generally relating to the collection and use of racial and ethnic variations data
- The system, where appropriate shall solicit performance information from enrollees of health maintenance organizations; and on or before October 1, 2007, to the extent feasible, incorporate information on racial and ethnic variations.

HB 357 – Maryland Fetal and Infant Mortality Review

- Establishing a Fetal and Infant Mortality Review Program in the Department of Health and Mental Hygiene to prevent or reduce infant deaths by determining contributing factors to fetal and infant deaths and developing recommendations to address them; implementing prevention or reduction strategies; recommending legislative or budgetary initiatives to the Governor and the General Assembly to prevent or reduce deaths and advising the Governor and General Assembly, and the public on necessary changes to prevent or reduce deaths. The State Team functions include conducting statistical analyses of the incidence and underlying factor for fetal and infant mortality in Maryland, including focus on local jurisdictions and regions; analyzing reports from local teams; assisting local teams in developing, implementing or evaluating community activities intended to reduce fetal and infant mortality; and evaluating the continued effectiveness and efficiency of the program and make appropriate changes
- Submission of Annual report by October 1, each local team must submit to the State an annual report regarding the local team's activities and recommendations.

HB 524 – Workgroup on Cultural Competency and Workforce Development for Mental Health Professionals

- The Mental Health Transformation Working Group, in collaboration with the Mental Hygiene Administration and the Office of Minority Health and Health Disparities to convene a Workgroup on Cultural Competency and Workforce Development for Mental Health Professionals; requiring the Workgroup to include representatives from certain groups; providing for the purpose and goals of the Workgroup; requiring the Workgroup to develop certain recommendations; requiring the Workgroup to submit a certain report to the Governor and the General Assembly on or before a certain date; providing for the termination of Workgroup on Cultural Competency and Workforce Development for Mental Health Professionals

- The Act shall take effect July 1, 2007 and remain effective for a period of 1 year and end June 30, 2008.

HB 793 – Sickle Cell Disease – Adults – Best Practices Treatment and Awareness Act

- Establish a Statewide Steering Committee on Services for Adults with Sickle Cell Disease; requiring the Steering Committee to establish institution and community partnerships; establish a statewide network of stakeholders who care for individuals with sickle cell disease (SCD); develop and implement, and lead state comprehensive education and treatment programs for adults with SCD; develop and implement sickle cell awareness and education programs for health care providers; educate individuals with SCD, the public, and health care providers about state options for care of SCD and seek grant funding to develop and establish a case management system for adults with SCD and establish an adult SCD day infusion center
- The Act shall take effect October 1, 2007.

HB 788 – Health Insurance – Collection of Racial and Ethnic Data – Nondiscrimination

- Authorizing entities that provide health insurance to make an inquiry about race and ethnicity under certain circumstances, and subject to certain limitations; prohibiting the use of certain racial and ethnic information of deny or otherwise affect a health insurance policy or contract; making certain provisions of law applicable to health maintenance organizations; generally relating to the collection and use of racial and ethnic data by insurers that provide health insurance
- This Act shall take effect October 1, 2007.

HB 283 – Charles County Prostate Cancer Pilot Program

- Establishes the Charles County Prostate Cancer Pilot Program to fund prostate cancer education, screening and treatment to men in Charles County; program open to uninsured or economically challenged men at least 50 years old and do not have health insurance; and on the advice of a physician or at the request of individual, uninsured or economically challenged men who are over 35 years old but under the age of 50 year who at are high risk for prostate cancer; program will provide prostate cancer screening, referral services, treatment services, outreach and education activities to ensure awareness and utilization of program services by uninsured men and economically challenged men. The program shall be funded as provided by the State budget; Department shall distribute grants to administer the program to: local health department and federally qualified health center in Charles County
- On or before September 1, 2010, the Department must report to the Governor and General assembly on the number of individuals screened and treated by the program, including racial and ethnic data on individuals and to the extent possible any cost savings achieved by the program as a result of early detection of prostate cancer.

Quality Improvement Initiatives to Address Health Disparities Passed by the Maryland General Assembly in 2006

During the 2006 legislation session, the General Assembly passed several initiatives designed to address health disparities. The initiatives focused on specific diseases that have a disproportionate impact among minority populations, such as Hepatitis C and sickle cell anemia. Legislation passed that will provide the State with data necessary to reduce health disparities. Further, there were two bills passed to increase the number of minorities working in health care professions.

Disease Prevention - Hepatitis C Advisory Council *[House Bill 342]*

- Requires Department of Health and Mental Hygiene (DHMH) to: 1) conduct a needs assessment on Hepatitis C; 2) initiate a statewide public awareness campaign; 3) coordinate with other units of State government to activate a Hepatitis C Virus Plan; 4) solicit funding; 5) provide funding for Hepatitis C Virus pilot programs, if funds are available; 6) promote education and awareness of Hepatitis C; 7) assess the feasibility of creating a Hepatitis C Virus Administration in DHMH; and 8) implement the 2005 report of the Hepatitis C Advisory Council, as funds are available.

Adult Sickle Cell Anemia - Study *[House Bill 851]*

- Requires DHMH to report on adult sickle cell anemia in Maryland to specified legislative committees by December 1, 2006.
- The report shall include recommendations to: 1) improve the quality of health care delivery to adults in the State with sickle cell anemia, 2) reduce the mortality rate of adults in the State with sickle cell anemia, 3) assist health care institutions in the State that have clinics for adults with sickle cell anemia. The report will also include the amount of State funds necessary to implement the recommendations.

Health Care Disparities Report Card *[Department of Health and Mental Hygiene – Racial and Ethnic Variations – Health Care Disparities Report Card (House Bill 58)]*

- Requires the Maryland Health Care Commission and the Office of Minority Health and Health Disparities to collaborate in the development of a "Health Care Disparities Policy Report Card."

Department of Health and Mental Hygiene - Cultural Competency and Health Outcomes - Pilot Program *[House Bill 1455]*

- Requires the Family Health Administration and the Office of Minority Health and Health Disparities to provide technical assistance to qualified community-based entities to implement a pilot program that addresses: 1) cultural competency training of health care providers, and 2) health outcomes and community-based models for targeting health outcomes as determined by tracking indicators relating to the specific health care needs of certain populations.

Higher Education – Nurse Support Program Assistance Fund – Hospital Rates *[House Bill 322]*

- Creates a Nurse Support Program Assistance Fund to distribute competitive grants and statewide grants to increase the number of qualified bedside nurses in Maryland hospitals and a portion of the grants are to be used to attract and retain minorities to nursing and nurse faculty careers in Maryland.

Statewide Commission on the Shortage in the Health Care Workforce *[House Bill 1127]*

- Creates a Commission to study the shortage of health care workers in the state. Two annual reports are due to the General Assembly and will include: 1) the extent of the health care workforce shortage, including an evaluation of mechanisms currently available in the state and elsewhere intended to enhance education, recruitment, and retention of health care workers, 2) examination of what changes are needed, 3) develop recommendations on, and facilitate implementation of, strategies to reverse the growing shortage of health care workers in the state, and 4) identify methods to:
    - Recruit minorities into the health care workforce
    - Recruit high school students into the health care workforce
    - Recruit and facilitate the long-term retention of health care workers in rural and underserved areas in the state; and
    - Facilitate career advancement and retention of health care workers.

Maryland Annotated Code Health – General
Title 20 – Miscellaneous Health Provision
Subtitle 10 – Office of Minority Health and Health Disparities

§ 20-1001. Definitions.

(a) In general.- In this subtitle the following words have the meanings indicated.

(b) Director.- "Director" means the Director of the Office of Minority Health and Health Disparities.

(c) Minority person.- "Minority person" includes African Americans, Hispanics, Asian and Pacific Islanders, and American Indians statewide.

(d) Office.- "Office" means the Maryland Office of Minority Health and Health Disparities established under § 20-1002 of this subtitle.

§ 20-1002. Office established.

There is an Office of Minority Health and Health Disparities in the Department.

§ 20-1003. Director.

The Director shall report to the Secretary.

§ 20-1004. Duties of Office.

The Office shall:

(1) Be an advocate for the improvement of minority health care by working with the Department on its own, or in partnership with other public and private entities to establish appropriate forums, programs, or initiatives designed to educate the public regarding minority health and health disparities issues, with an emphasis on preventive health and healthy lifestyles;

(2) Assist the Secretary in identifying, coordinating and establishing priorities for programs, services, and resources that the State should provide for minority health and health disparities issues;

(3) Collect, classify, and analyze relevant research information and data collected or compiled by:

(i) The Department;

(ii) The Department in collaboration with others; and

(iii) Other public and private entities;

(4) Research innovative methods and obtain resources to improve existing data systems to ensure that the health information that is collected includes specific race and ethnicity identifiers;

(5) Serve as a clearinghouse and resource library for information about minority health and health disparities data, strategies, services, and programs that address minority health and health disparities issues;

(6) Develop a strategic plan to improve public services and programs targeting minorities;

(7) Obtain funding and, contingent upon funding, provide grants to community-based organizations and historically black colleges and universities to conduct special research, demonstration, and evaluation projects for targeted at-risk racial and ethnic minority

populations and to support ongoing community-based programs that are designed to reduce or eliminate racial and ethnic health disparities in the State;
(8) Develop criteria for the awarding of grants for programs that are designed to improve minority health care;
(9) Review existing laws and regulations to ensure that they facilitate the provision of adequate health care to the minorities of this State;
(10) Recommend to the Secretary any additions or changes to existing laws and regulations designed to facilitate the adequate provision of health care to minorities in this State;
(11) Identify and review health promotion and disease prevention strategies relating to the leading health causes of death and disability among minority populations;
(12) Develop and implement model public and private partnerships in racial and ethnic minority communities for health awareness campaigns and to improve the access, acceptability, and use of public health services;
(13) Develop recommendations for the most effective means of providing outreach to racial and ethnic minority communities throughout the State to ensure their maximum participation in publicly funded health benefits programs;
(14) Develop a statewide plan for increasing the number of racial and ethnic minority health care professionals which includes recommendations for the financing mechanisms and recruitment strategies necessary to carry out the plan;
(15) Work collaboratively with universities and colleges of medicine, nursing, pharmacy, and dentistry in this State and other health care professional training programs to develop courses with cultural competency, sensitivity, and health literacy, that are designed to address the problem of racial and ethnic disparities in health care access, utilization, treatment decisions, quality, and outcomes;
(16) Work collaboratively with the Maryland Health Care Disparities Initiative, the Morgan-Hopkins Center for Health Disparities Solutions, the University of Maryland Disparity Project, the Monumental City Medical Society, faculty and researchers at historically black colleges and universities, and other existing alliances or plans, to reduce or eliminate racial and ethnic disparities in the State;
(17) Seek to establish a statewide alliance with community-based agencies and organizations, historically black colleges and universities, health care facilities, health care provider organizations, managed care organizations, and pharmaceutical manufacturers to promote the objectives of the Office;
(18) Evaluate multicultural or racial and ethnic minority health programs in other states to assess their efficacy and potential for replication in this State and make recommendations regarding the adoption of such programs, as appropriate;
(19) Apply for and accept any grant of money from the federal government, private foundations, or other sources which may be available for programs related to minority health and health disparities;
(20) Serve as the designated State agency for receipt of federal funds specifically designated for minority health and health disparities programs; and
(21) Work collaboratively with the Office of Minority Affairs as the Office determines necessary; and

(22) In collaboration with the Maryland Health Care Commission, publish annually on the Department's website and provide in writing on request a "Health Care Disparities Policy Report Card" that includes:
(i) An analysis of racial and ethnic variations in insurance coverage for low-income, nonelderly individuals;
(ii) The racial and ethnic composition of the physician population compared to the racial and ethnic composition of the State's population; and
(iii) The racial and ethnic disparities in morbidity and mortality rates for cardiovascular disease, cancer, diabetes, HIV/AIDS, infant mortality, asthma, and other diseases identified by the Maryland Health Care Commission.

§ 20-1005. Duties of Director.
Subject to the limitations of any law that governs the activities of other units of the Executive Branch of State government, the Director shall:
(1) Promote health and the prevention of disease among members of minority groups;
(2) Distribute grants from available federal and special funds to community-based health groups to be used to promote health and the prevention of disease among members of minority groups; and
(3) Fund projects which are innovative, culturally sensitive, and specific in their approach toward reduction of the incidence and severity of those diseases or conditions which are responsible for excess morbidity and mortality in minority populations.

§ 20-1006. Reports.
(a) In general.- On or before the 15th day of each regular session of the General Assembly, the Department shall submit an annual report on the Office of Minority Health and Health Disparities to the Governor and, subject to § 2-1246 of the State Government Article, to the General Assembly.
(b) Contents.- The report shall include the projects and services developed and funded by the Office and the health care problems that the grant funds are intended to ameliorate.
(c) Recommendations.- The report may include any recommendations for administrative or legislative action that it deems appropriate.

§ 20-1007. Funding.
It is the intent of the General Assembly that the Office be funded from federal and special funding sources.

Maryland Annotated Code Health – General
Title 20 – Miscellaneous Health Provision
Subtitle 9 – Health Care Services Disparities Prevention

§ 20-901. Purpose.

In adopting this subtitle, the General Assembly intends to encourage courses or seminars that address the identification and elimination of health care services disparities of minority populations as part of:

(1) Curriculum courses or seminars offered or required by institutions of higher education;

(2) Continuing education requirements for health care providers; and

(3) Continuing education programs offered by hospitals for hospital staff and health care practitioners.

§ 20-902. Curriculum courses or seminars addressing health care services disparities of minority populations.

(a) In general.- An institution of higher education in the State that includes in the curriculum courses necessary for the licensing of health care professionals in the State may include in the curriculum courses or offer special seminars that address the identification and elimination of health care services disparities of minority populations as reported in the findings of:

(1) The Institute of Medicine's report "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care"; and

(2) The Surgeon General's "Healthy People 2020" report.

(b) Issues to be addressed.- The courses or special seminars described under subsection (a) of this section shall address, with cultural competence, sensitivity, and health literacy the issue of health care services disparities of minority populations identified by:

(1) Race;

(2) Ethnicity;

(3) Poverty; and

(4) Gender.

§ 20-903. Continuing education unit to address health care services disparities of minority populations.

A hospital with a continuing education program may offer and require the hospital's medical staff and health care practitioners to take a continuing medical education or continuing education unit course that addresses health care services disparities of minority populations.

§ 20-904. Development of plan to reduce health care disparities [Section subject to abrogation].

(a) In general.- The Department, in consultation with the Maryland Health Care Foundation, shall develop and implement a plan to reduce health care disparities based on gender, race, ethnicity, and poverty.

(b) Contributing entities.- The following entities shall be involved in the development and implementation of the plan:

(1) The Medical and Chirurgical Faculty of Maryland;
(2) The Monumental City Medical Society;
(3) The Nurse Practitioners Association of Maryland;
(4) The Maryland Academy of Physician Assistants;
(5) The Mental Hygiene Administration;
(6) The Center for Poverty Solutions;
(7) The Maryland Hospital Association;
(8) An academic medical center in the State;
(9) A medical school in the State;
(10) The Johns Hopkins Bloomberg School of Public Health;
(11) The Morgan State University Graduate Public Health Program;
(12) A nursing program in the State that offers a bachelor's degree in nursing;
(13) A nursing program in the State that offers an associate's degree in nursing;
(14) The National Black Nurses Association;
(15) The Baltimore City Medical Society;
(16) The Maryland Nurses Association;
(17) The University of Maryland School of Social Work;
(18) The Baltimore Prevention Coalition;
(19) The Maryland Association of County Health Officers;
(20) The Maryland Higher Education Commission;
(21) The Mid-Atlantic Association of Community Health Centers; and
(22) Any other organization with an interest or expertise in reducing health care disparities.

(c) Staffing.- The following entities shall assist the Department in providing staff to implement the plan:
(1) The Maryland Health Care Foundation;
(2) The Morgan State University Graduate Public Health Program;
(3) The Johns Hopkins Bloomberg School of Public Health; and
(4) The Monumental City Medical Society.

(d) Contents.- The plan shall include recommendations to coordinate existing programs related to health care disparities by:
(1) Identifying available funding;
(2) Identifying any gaps in service delivery based on gender, race, ethnicity, and poverty;
(3) Reducing the duplication of available health care services;
(4) Reducing the fragmentation of health care services;
(5) Identifying outcome measures to reduce health care disparities; and
(6) Assessing the establishment of a Minority Health Advisory Commission to be composed of representatives from the Legislative and Executive branches that would assist the Office of Minority Health and Health Disparities.

(e) Model course or seminar.- By September 30, 2004, the Department and the entities listed in subsection (b) of this section shall:
(1) (i) Examine current continuing education programs offered by hospitals and physician organizations in the State that are focused on health care disparities; and
(ii) Examine current continuing education requirements of health occupation boards;
(2) Determine the content of a model course or seminar that addresses health care services disparities of minority populations;

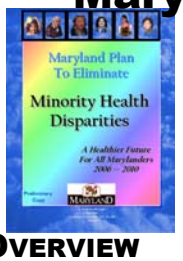
(3) Assess the feasibility of requiring certain health care providers to take the course or seminar; and

(4) Identify the oversight that would be required by a health occupation board in order to determine compliance with continuing education requirements concerning health care disparities.

(f) Report.- The Department shall submit a report to the Governor and, subject to § 2-1246 of the State Government Article, the Senate Education, Health, and Environmental Affairs Committee and the House Health and Government Operations Committee by September 30 of each year, on the development and implementation of the plan to reduce health care disparities.

FACT SHEET

Maryland Plan to Eliminate Minority Health Disparities, *preliminary copy*



Minority Health and Health Disparities
Maryland Department of Health and Mental Hygiene

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Maryland Department of Health and Mental Hygiene

OVERVIEW

The first *Maryland Plan to Eliminate Minority Health Disparities* was released in December of 2006. The development of the Plan, two years in the making, was a coordinated effort of the Maryland Office of Minority Health and Health Disparities (MHHD), the public, health professionals, academia, community health groups, other stakeholders and the Maryland Department of Health and Mental Hygiene (DHMH). The Plan offers a discussion, with accompanying data, on health disparities in Maryland as well as the nation. The most important feature of the Plan is the compilation of public comment from over 1,200 citizens. Next steps for the Plan involve promoting active change throughout the state within the public and private sectors.

PURPOSE

The development of the Plan is intended to:

- Provide information to assist Maryland's communities in planning and implementing ways to eliminate minority health disparities
- Promote a dialogue across Maryland on the causes, solutions and challenges faced by the state pertaining to minority health disparities

METHODS

The methodological approach of the Plan was to:

- Examine a broad array of research literature, reports and data about disparities, workforce diversity, and cultural competency
- Solicit input from a variety of sources

Outreach activities to solicit input for the Plan included:

- Expert health disparities planning committees (4)
- Town hall meetings (6)
- Racial/ethnic focused health roundtables (5)
- Annual health disparities conferences (3)
- The Maryland Health Disparities Website
- Minority Outreach and Technical Assistance (MOTA) Grantees

CONTENT

The Plan provides the following information on health disparities:

- The overview outlines concepts needed to understand health disparities. It presents national data and information on causes of health disparities, the impact of disparities, selected disparities in disease morbidity and mortality, unequal access to healthcare, quality of care and the under-representation of minorities in the health professions
- The next section outlines Maryland data and information on selected health disparities in mortality, disease occurrence, disease risk factors, health insurance and access to quality healthcare
- The next section outlines challenges and solutions to eliminating minority health disparities in Maryland, including a summary of many ideas recommended by citizens throughout the state's jurisdictions
- The final section outlines next steps needed for Maryland to move from the Plan to an Action Agenda

Emerging Issues in Addressing Maryland Health Disparities

The key strategies that emerged from the public discussions and dialogues are:

- Capitalize on the wealth of resources that currently exist in the state
  - Promote coordination, partnerships and communication with public, private, academic, grassroots & community groups
  - Develop a state-wide advisory group for all entities working on health disparities
  - Empower grassroots organizations and community groups
- Ensure access to care by providing quality care in a timely fashion and in a culturally and linguistically meaningful way
  - Foster collaborations with state and key stakeholders
  - Remove barriers healthcare
  - Develop and use evidence-based guidelines
  - Apply culturally consistent patient-centered interventions
- Diversify the health workforce community and increase cultural competence of all healthcare providers
  - Enhance preparation of students in mathematics and sciences
  - Increase number of minority students in mathematics and sciences
  - Facilitate the training and preparation of foreign-trained health workers
  - Provide cultural competency training to healthcare professionals
- Ensure that complete and accurate racial and ethnic information becomes part of all health and healthcare data systems
  - Analyze reports on health status and healthcare quality by race and ethnicity
  - Collect data on racial and ethnic minority groups and sub-groups
  - Standardize Maryland's health data systems methods
- Identify funding strategies to support extensive resources needed
  - Fund pilot projects
  - Fund demonstration projects within DHMH
  - Fund the state's public education system
  - Foster collaborations between centers for health disparities
  - Provide resources for MHHD to develop effective infrastructure

Future Plans and Implementation

In calendar year 2007, MHHD will take steps to promote active change throughout Maryland's healthcare system. To do this, MHHD will:

- Convene work sessions with health professional academic institutions to review existing standards that promote cultural competency and collaborate in advancing practical applications and sharing best practices to address minority health disparities
- Take strategic action steps that target the reduction of specific health disparities among affected groups in Maryland
- Develop partnerships among public and private sector agencies and advocacy groups to implement recommendations for change
-

For Further Information, Please Contact

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HEALTH DISPARITIES IN MARYLAND

December 2006

Many of the disparities seen nationally in health status, healthcare access and quality are also seen in Maryland. This section will describe selected health disparities in mortality, disease occurrence, disease risk factors, health insurance and access to healthcare that exist in Maryland. It will also present, for some conditions, a comparison of disparities in the occurrence of the disease with the disparities in the consequences of the disease: healthcare utilization, disease complications, and deaths from the disease. These comparisons provide important first clues as to whether a focus on disease development disparities or on disease management disparities is more important for a particular disease.

Maryland's population was 39.6 percent minority in the 2004 vital statistics data [1], as shown in Table 1. By specific minority group, Maryland was 29.6 percent African American, 4.9 percent Asian, 5.4 percent Hispanic, and 0.4 percent American Indian. Because the African American population is 75 percent of Maryland's minority population, data for that group is the most extensive among the minority groups; this allows for a more statistically sound analysis in that population. For this reason, several analyses below are limited to comparisons of African Americans to Whites. In addition, the very small size of the Native American population makes analysis of their health disparities especially challenging. The Office of Minority Health and Health Disparities within the Department of Health and Mental Hygiene is committed to developing approaches to data collection and analysis that will allow us to improve data reporting for Maryland's smaller minority communities.

Table 1. Maryland Population by Race and Ethnicity, July 1, 2004

Race	All Ethnicity		Non-Hispanic		Hispanic	
White	3,617,094	65.1%	3,355,955	60.4%	261,139	4.7%
Non-White	1,940,964	34.9%	1,904,386	34.3%	36,578	0.7%
Black	*1,645,781*	*29.6%*				
Asian / Pac Isle	*274,298*	*4.9%*				
American Indian	*20,885*	*0.4%*				
MD total	5,558,058	100.0%	5,260,341	94.6%	297,717	5.4%

All percents are percentage of the total Maryland population.

Source: Maryland Vital Statistics Annual Report 2004 [1]

Several of the following analyses present age-adjusted data. Age-adjustment is a method of making a fair comparison between two groups regarding a condition whose impact is vastly different at different ages when the two groups have important differences in their age pattern. For most chronic diseases (which are also the leading causes of death), both the occurrence of the disease, and the mortality from the disease are greatest in persons at or above the age of 65. About 13 percent of Maryland Whites are 65 or older, while only about 8 percent of African Americans are that age [1]**.** This difference in age pattern makes the overall White death rate larger than the African American death rate if age is not taken into account. This is despite the fact that at any age, the death rate for African Americans is higher. Age-adjustment solves this problem, and is the correct way to assess disparity for most chronic conditions.

Minority Disparities in Mortality

Vital statistics data reveal that in 2004, age-adjusted all cause mortality for African Americans was 989 per 100,000, which was 1.3 times higher than for Whites (758 per 100,000) [1]**.** For other minority groups, the age-adjusted death rates from vital statistics data are lower than White rates, but this may be due to some limitations in the data unique to those groups. Death rates in vital statistics data are determined from information on death certificates. If there is misclassification of minorities as non-Hispanic Whites on death certificates, the count of minority deaths will be too low, and the minority death rate will be underestimated. This kind of error is uncommon for African Americans, and more common for the other groups.

A second source of underestimation of minority deaths would be the return of older foreign-born minority residents of the U.S. to their home country at the end of life. This would have a larger effect on the populations that have higher percentages of foreign-born residents. In Maryland, the percent foreign-born by racial and ethnic group is four percent for non-Hispanic Whites, nine percent for African Americans, 16 percent for American Indians, 56 percent for Hispanics, and 72 percent for Asians [2].

These two factors may be underestimating death rates for Asians, American Indians, and Hispanics. Therefore this section focuses on mortality disparities between African Americans and Whites (unless otherwise stated, Hispanic and non-Hispanic are combined within a race, as this is how the vital statistics data are routinely presented).Table 2 shows the age adjusted mortality rates for the 15 leading causes of death in Maryland by White or African American race in 2004 [1]. It also presents the ranking of the disparity in two ways: a ranking based on taking a ratio of the two rates, and a ranking based on taking the difference between the two rates. The ratio approach is the best way to examine the disparity in the mortality risk to an individual, and does not depend on how common death is from that disease. The mortality rate difference approach is the best way to see the overall societal impact of the disparity. This measure gives higher ranks to the more common causes of death, and gives a sense of the number of preventable deaths due to the disparity in that disease.

Table 2. African American vs. White Mortality Disparity for the 15 Leading Causes of Death, Maryland 2004

Ratio Disparity Rank	Excess Rate Disparity Rank	Statewide Cause of Death Rank	Disease	Age-adjusted Mortality per 100,000 Black	White	Ratio	Age-adjusted Difference per 100,000
8	1	1	Heart Disease	256.2	201.5	1.27	54.7
9	2	2	Cancer	216.7	183.7	1.18	33.0
7	7	3	Stroke	62.7	48.3	1.30	14.4
		4	Chronic Lung Disease	25.1	40.1	0.63	-15.0
4	4	5	Diabetes	45.2	21.8	2.07	23.4
11	11	6	Accidents	27.2	25.4	1.07	1.8
10	10	7	Flu & Pneumonia	23.6	21	1.12	2.6
6	6	8	Septicemia	32.1	16.9	1.90	15.2
12	12	9	Alzheimer's Disease	17.7	17.5	1.01	0.2
1	3	10	HIV / AIDS	28.2	2.2	12.82	26.0
4	8	11	Kidney diseases	22.1	10.7	2.07	11.4
2	5	12	Homicide	24.3	3.3	7.36	21.0
		13	Chronic Liver Disease	6.7	7.8	0.86	-1.1
		14	Suicide	4.3	10.9	0.39	-6.6
3	9	15	Certain Perinatal	13.3	4.1	3.24	9.2

Source: Maryland Vital Statistics Annual Report 2004 [1]

All of the 15 leading causes of death except for chronic lung disease, chronic liver disease, and suicide have higher mortality for African Americans. The diseases that rank highest for disparity, expressed as the difference between rates, are heart disease, cancer, HIV/AIDS, diabetes, and homicide. The diseases that rank highest for disparity, expressed as a ratio of the rates, are HIV/AIDS, homicide, perinatal deaths, diabetes, and kidney diseases (tied with diabetes). The mortality rate ratios for HIV/AIDS (12.8 to 1) and homicide (7.4 to 1) are striking compared to the other rate ratios in the table (all of which are less than 3.3 to 1).

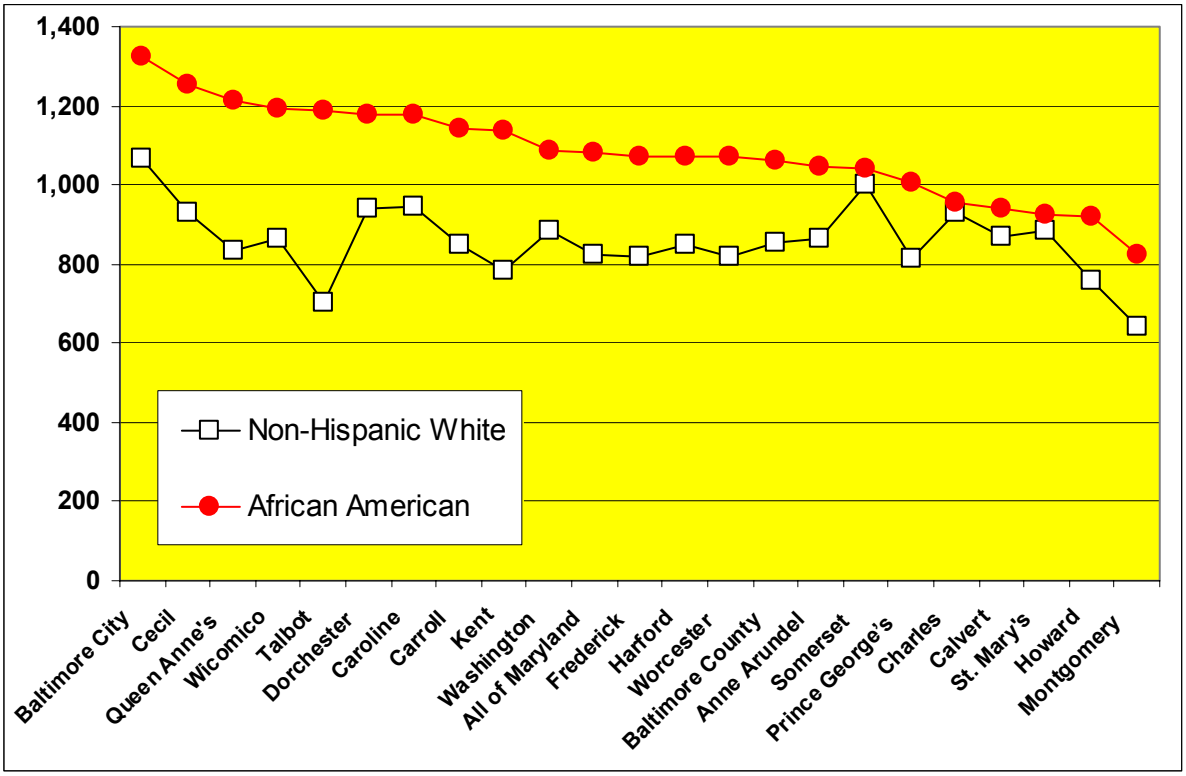
Heart disease and cancer are examples of diseases that rank high in the rate difference approach due to being the most common causes of death. The rate ratios are relatively low (1.3 to 1 for heart disease and 1.2 for cancer), so they rank much lower on the rate ratio approach.

Kidney diseases and perinatal deaths rank high in the rate ratio approach, but since they are less common causes of death, rank lower in the rate difference approach.

HIV/AIDS, diabetes, and homicide rank high in both approaches to ranking disparities, while accidents, influenza/pneumonia and Alzheimer's disease rank low by both approaches.

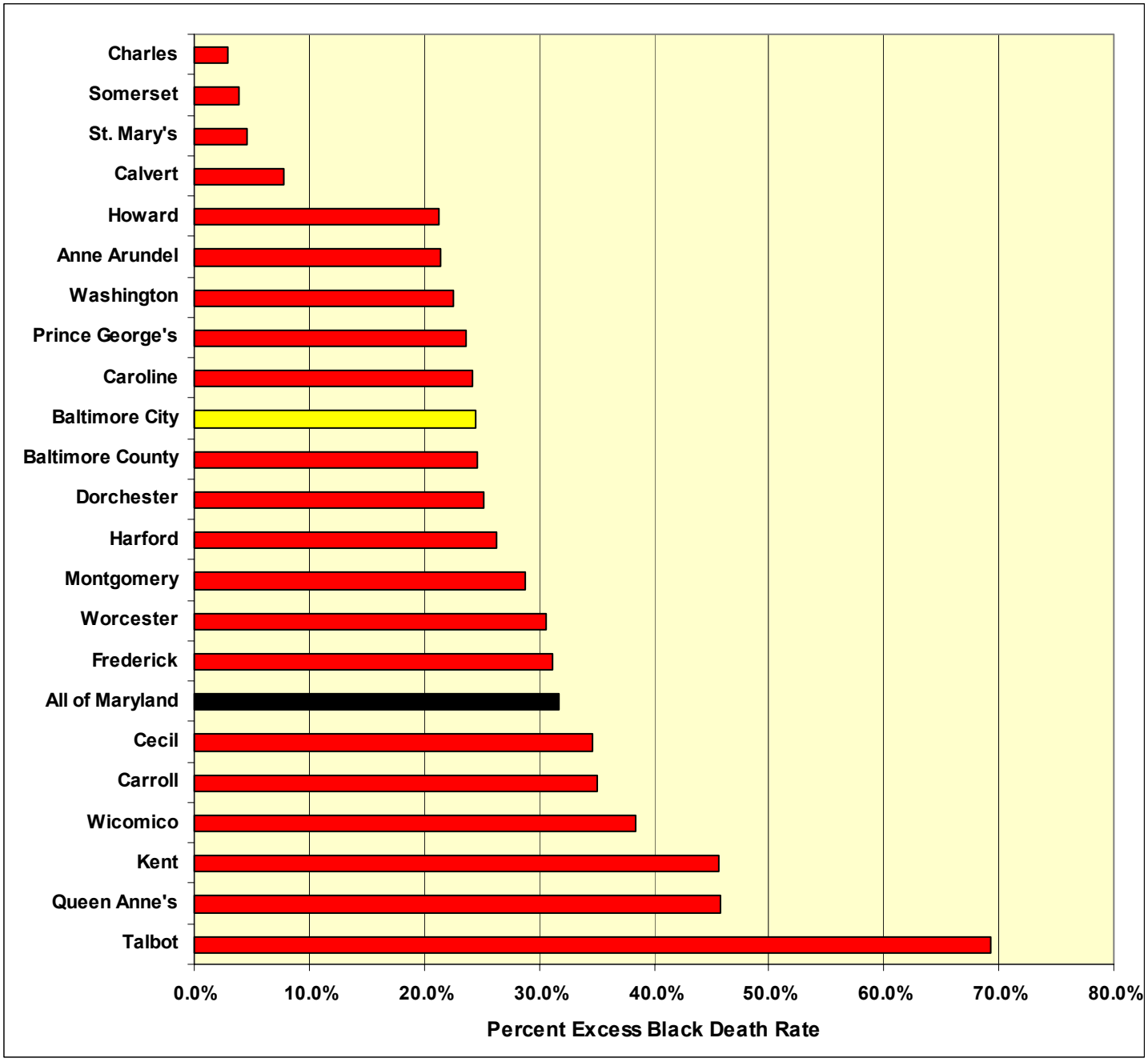
Figure 1 shows the African American and White all-cause mortality by jurisdiction, based on pooled vital statistics data from 2001-2003 [3]. Figure 2 plots the percent by which the African American rate exceeds the White rate in each jurisdiction [3]. Age-adjusted rates for African Americans could not be calculated in Allegany and Garrett counties. These figures demonstrate that disparities exist in all Maryland jurisdictions where the comparison can be made. Disparities are not unique to the jurisdictions with the highest African American populations (Baltimore City, Prince George's County), and the disparity (expressed as a ratio) is larger in 12 jurisdictions than in Baltimore City.

Figure 1. Age-Adjusted All-Cause Mortality (rate per 100,000) by White or Black Race and Jurisdiction, Maryland 2001- 2003 Pooled



Source: Maryland Vital Statistics Administration Data [3]

Figure 2. Excess Black Death Rate (Compared to Non-Hispanic Whites) In Maryland, by Jurisdiction, 2001-03 Combined



Age-adjusted to the projected U.S. 2000 population

Age-adjusted death rates for Blacks could not be calculated for Garrett or Allegany Counties.

Source: Maryland Vital Statistics Administration Data [3]

These figures also demonstrate that there are geographic disparities within the two racial groups. The ratio of worst to best mortality in African Americans and in Whites is the same as the ratio of the African American to White mortality in the county with the largest disparity ratio. As the efforts to reduce minority health disparities reduce barriers to access, improve quality, and educate the public, the effect should be to also reduce disparities based on geography and other factors, and improve the health of all Marylanders.

Finally, it is worth noting that the African American death rate in Montgomery County is lower that the White death rate in 15 other jurisdictions. This finding demonstrates that there is nothing inevitable about minorities having poorer health than Whites, which means that minority health disparities can be successfully addressed.

Minority disparities in death rates do not discriminate by gender: the disparities are seen for women and for men. This is shown in Table 3 [1]. In 2004, the age-adjusted all cause mortality rate for African American women was 25 percent higher than the rate in White women, while the mortality rate for African American men was 37 percent higher than the rate for White men.

Table 3. Disparity in Age-Adjusted All-Cause Mortality by Sex, Maryland 2004

Mortality Rate in Deaths per 100,000

	Black Mortality	White Mortality	Black/White Rate Ratio	Black - White Rate difference Per 100,000
Female	818.9	654.2	1.25	164.7
Male	1220.8	888.0	1.37	332.8

Source: Maryland Vital Statistics Annual Report 2004 [1]

There are also certain gender-specific conditions where disparities exist, such as prostate cancer for men, and breast cancer and cervical cancer for women. The disparities in mortality from these gender-specific cancers are given in Table 4 [4].

It is noteworthy that compared to White women, African American women have higher breast cancer mortality despite lower rates of new cases of breast cancer. This suggests that African American women have breast cancer diagnosed at later stages, and may experience more barriers to accessing timely, high-quality breast cancer treatment.

For prostate cancer in men, the rate of new cases is 1.4 times higher for African Americans than for Whites, and African American mortality is 2.6 times higher. The reasons for this are likely to be similar to those for breast cancer: later stage of diagnosis, and more barriers to timely and high-quality treatment.

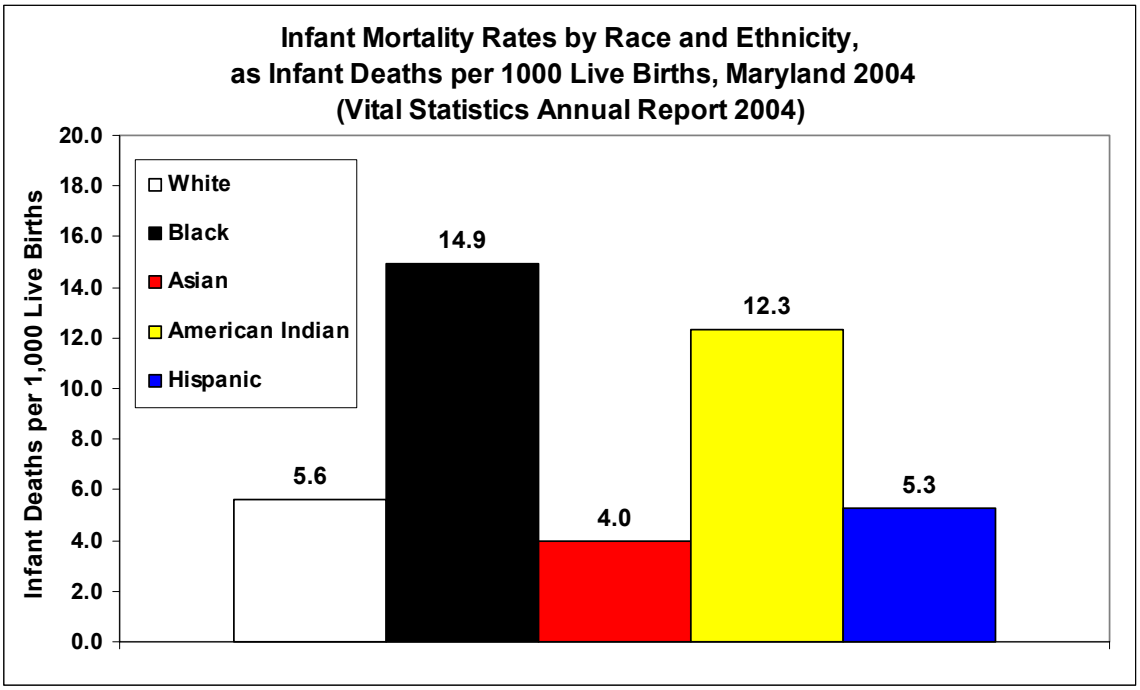
Table 4. Disparity in Age-Adjusted Mortality from Gender-Specific Cancers, Maryland 2001.

Mortality Rate in Deaths per 100,000	Black Mortality	White Mortality	Black/White Rate Ratio	Black - White Rate difference Per 100,000
Females				
Breast Cancer	32.0	25.9	1.24	6.1
Cervical Cancer	4.6	2.3	2.00	2.3
Males				
Prostate Cancer	65.7	25.1	2.62	40.6

Source: Maryland Annual Cancer Report 2004 [4]

Unfortunately, Maryland also experiences minority health disparities at the youngest end of the age spectrum: disparities in infant mortality. American Indians and African Americans experience high infant mortality rates compared to Whites. Infant mortality rates in 2004 are shown for all racial and ethnic groups in Figure 3 [1].

Figure 3. Infant Mortality Rates by Race and Ethnicity, Maryland 2004



Source: Maryland Vital Statistics Annual Report 2004 [1]

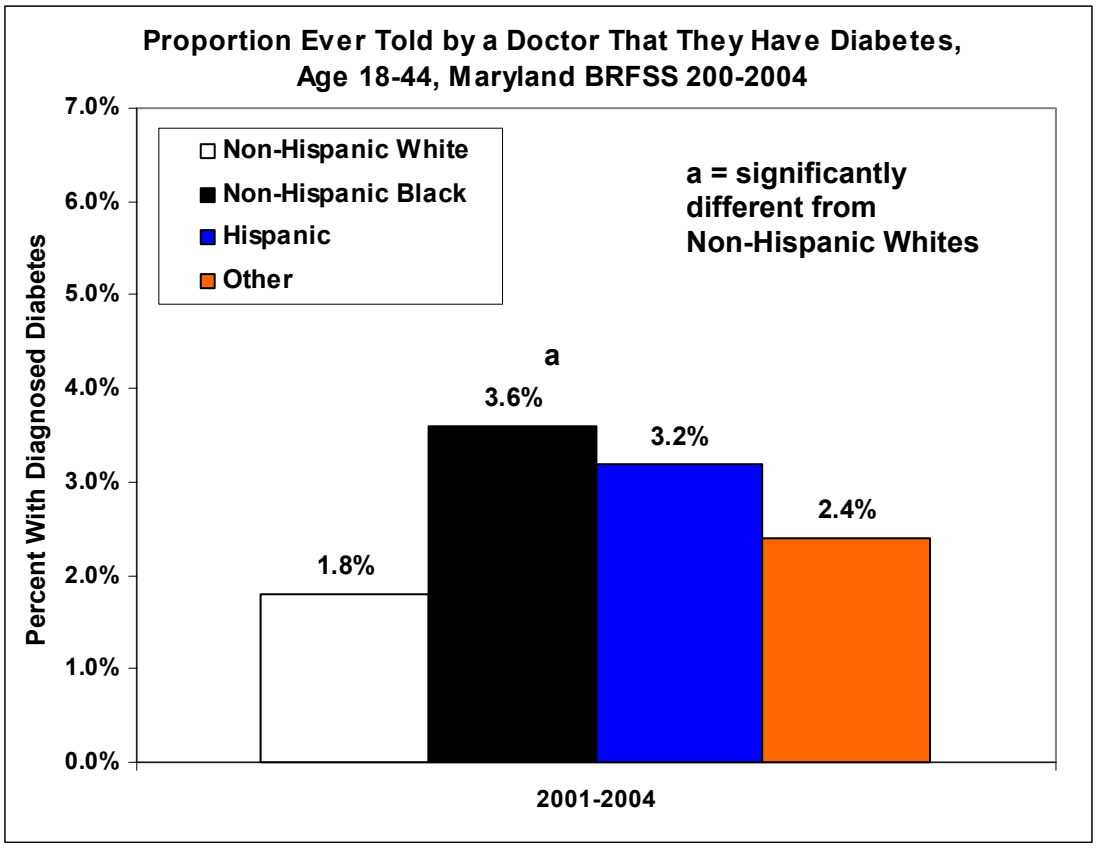
Minority Disparities in Disease Occurrence

Many factors potentially contribute to minority disparities in mortality rates. These may include a variety of factors that affect access and quality of healthcare, and a variety of factors that influence the rate of acquiring particular diseases or conditions. Maryland's minority populations experience disparities in the occurrence of various diseases, compared to the White population.

Disease occurrence is measured in two ways. **Incidence** of disease expresses the rate at which persons without the disease develop the disease. This can be applied to diseases that resolve, such as some infections and some injuries, or to chronic conditions that remain after onset. **Prevalence** of disease expresses the proportion of the population that has a disease at a particular time. This is usually used to describe chronic diseases, since it contains both the new cases and the old cases. Diabetes, high blood pressure, end-stage renal (kidney) disease, and HIV/AIDS are presented as examples of disparities in disease occurrence.

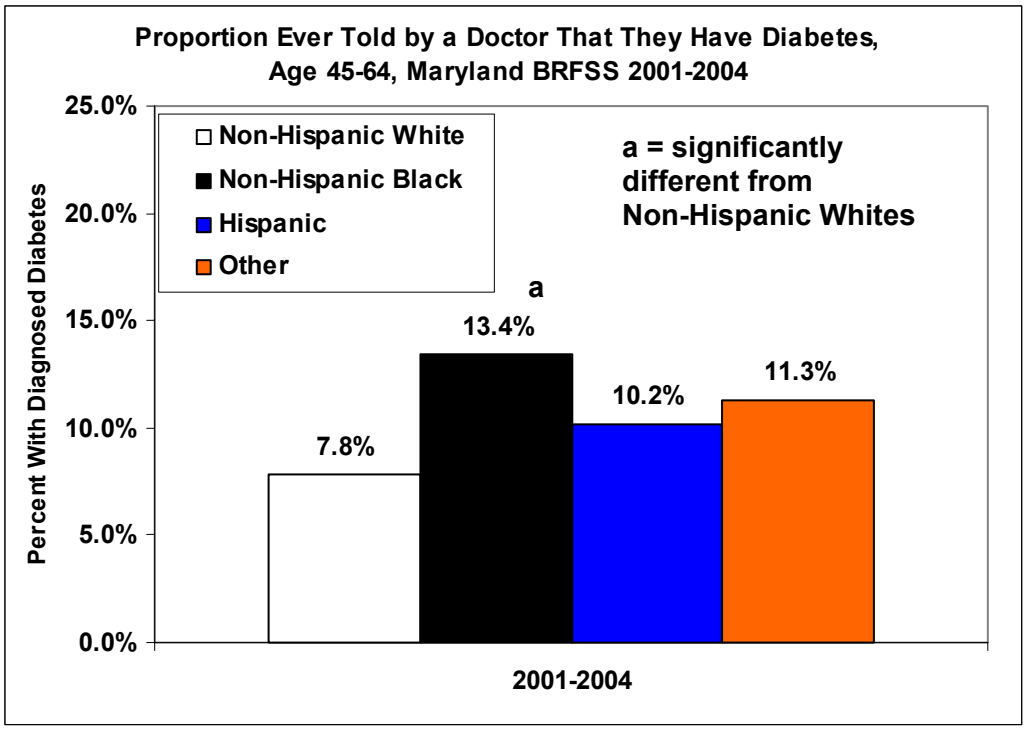
Diabetes. The prevalence (percent of people who have) a doctor diagnosis of diabetes in Maryland, by age group and race/ethnicity, is shown in the three figures below.

Figure 4. Prevalence of doctor diagnosed diabetes in adults age 18-44, by race/ethnicity, Maryland 2001-2004.



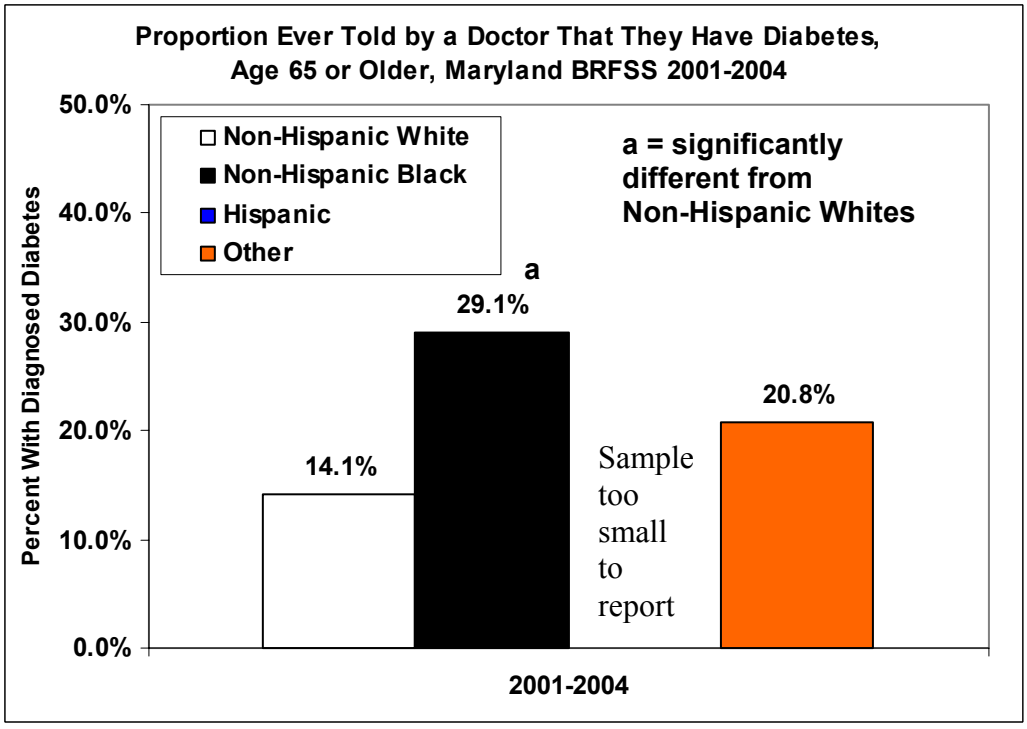
Source: Pooled data from Maryland BRFSS [5]

Figure 5. Prevalence of doctor diagnosed diabetes in adults age 45-64, by race/ethnicity, Maryland 2001-2004.



Source: Pooled data from Maryland BRFSS [5]

Figure 6. Prevalence of doctor diagnosed diabetes in adults age 65 or older, by race/ethnicity, Maryland 2001-2004.



Source: Pooled data from Maryland BRFSS [5]

Even with pooling of several years, there was insufficient data to separately report Asian and American Indian prevalence. And there was insufficient data to report the prevalence in Hispanics age 65 or older.

Separating the analysis into separate age groups is another way to adjust for age, and it reveals any differences between the age groups. The consistent finding for diabetes is that across all of these age groups, diagnosed diabetes is about twice as common for African Americans, and about 1.5 times as common for other minority populations, compared to non-Hispanic Whites [5]. The results for African Americans are statistically significant, meaning that the difference is larger than the margin of error for the survey. Due to small sample sizes for other minority groups, the margin of error for their comparison to non-Hispanic Whites is larger, and that comparison is not greater than the margin of error (not statistically significant). We expect that when additional years of data can be pooled, we will see a significantly higher prevalence of diagnosed diabetes in these smaller minority groups.

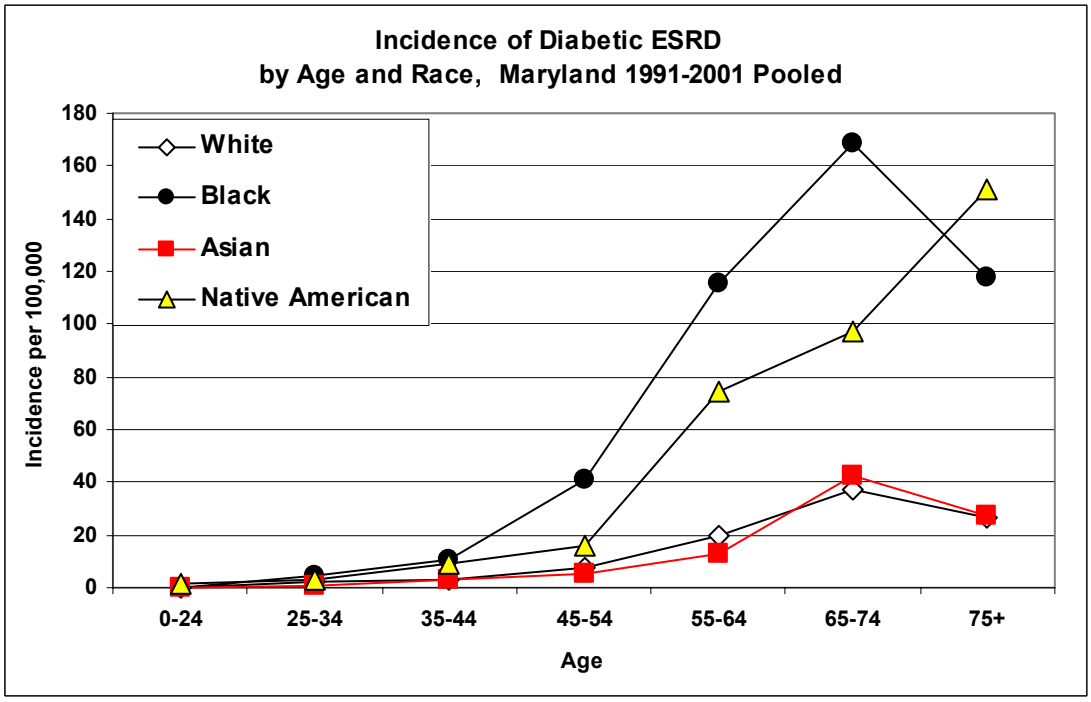
Diabetes can remain undiagnosed for several years after it develops, and minorities may well be more likely to have their diabetes undiagnosed due to their disparity in access to healthcare. So the disparities in total diabetes (diagnosed and undiagnosed) are probably even larger than the numbers presented here.

Hypertension. Similar analysis in the Behavior Risk Factor Surveillance System (BRFSS) for prevalence of diagnosis of high blood pressure (hypertension) by age group and race/ethnicity (data pooled from 2003 and 2004) reveal that compared to non-Hispanic Whites, African Americans have 14 percent more diagnosed hypertension at ages 18-44 (but not statistically significant), 33 percent more at ages 45-64 (statistically significant), and 15 percent more at ages 65 or older (statistically significant) [5].

In the survey, Hispanics have 42 percent less diagnosed hypertension than non-Hispanic Whites at ages 18-44 (this is statistically significant), 33 percent less at ages 45-64 (not statistically significant) and insufficient data to compare at ages 65 or older [5] . The lower rates of diagnosed hypertension in Hispanics could be an artifact of their barriers to access to healthcare: Hispanics in Maryland are the most uninsured race/ethnic group. In addition, BRFSS has not been administered in Spanish in Maryland until 2007, which excluded the portion of the Hispanic population that is likely to have the greatest number and severity of health problems.

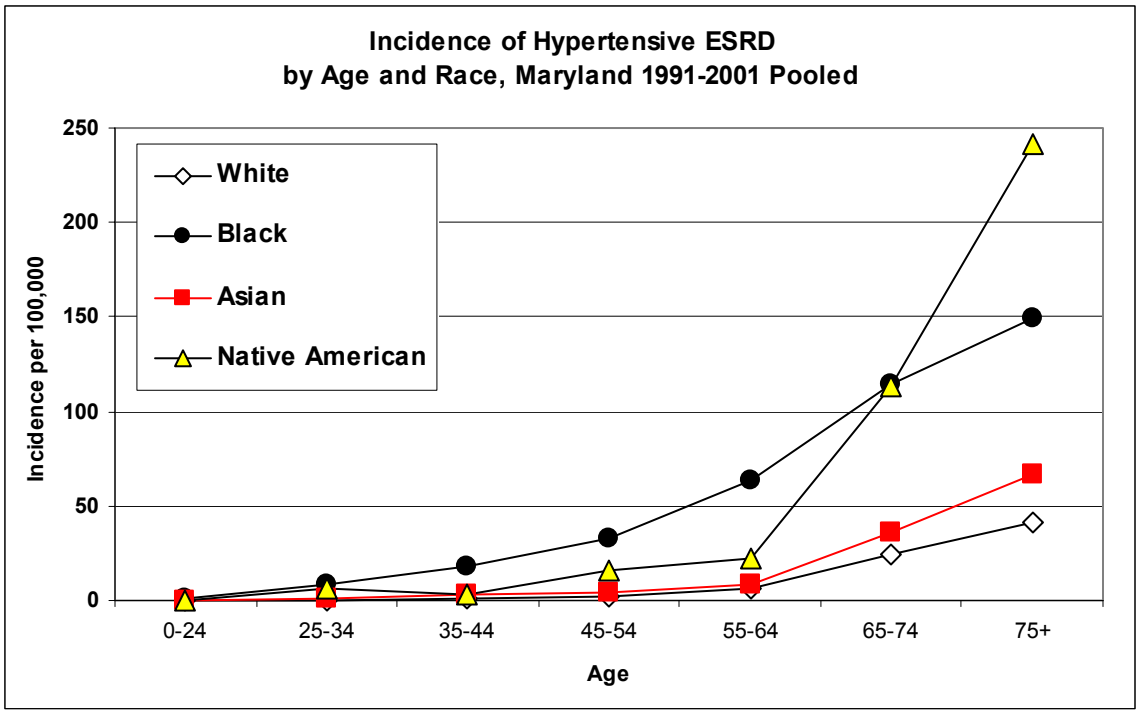
End-Stage Renal Disease. Diabetes and hypertension are the leading causes of end-stage renal (kidney) disease (ESRD) in Maryland, accounting for about 70 percent of cases [6]. Disparities in the new cases of ESRD for these causes are shown in following four figures.

Figure 7. Incidence of Diabetic End-Stage Renal Disease in Maryland, by Race 1991-2001 Pooled Data.



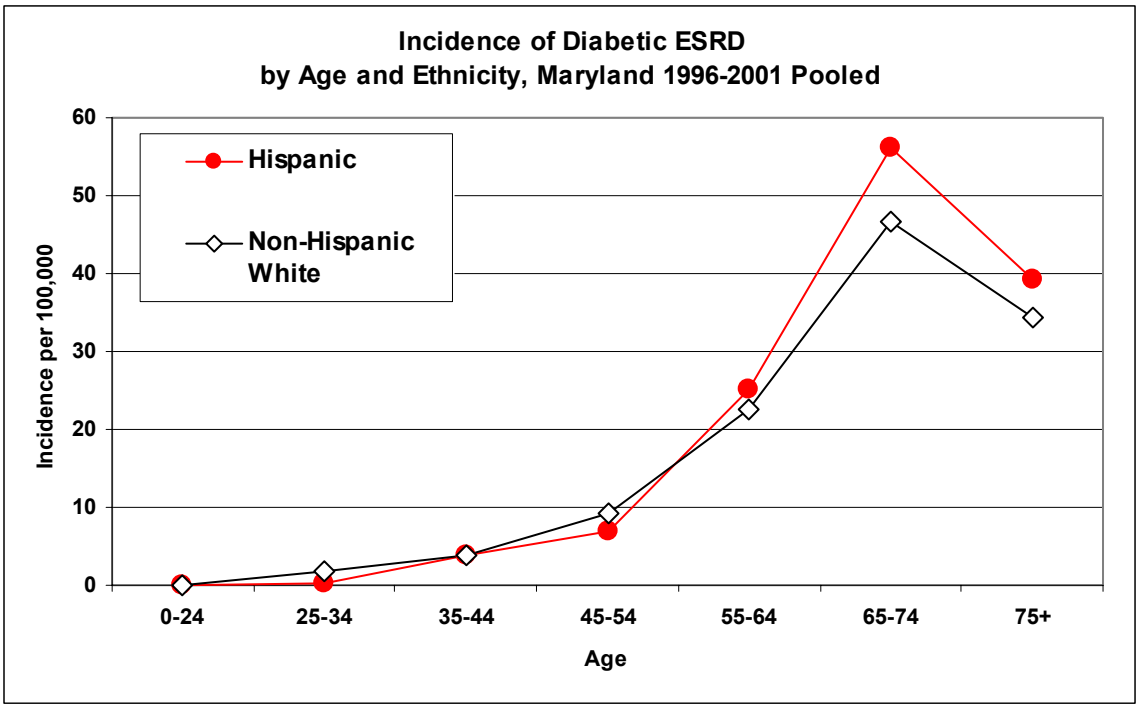
Source: DHMH analysis of U.S. Renal Data System Data [6]

Figure 8. Incidence of Hypertensive End-Stage Renal Disease in Maryland, by Race, 1991-2001 Pooled Data.



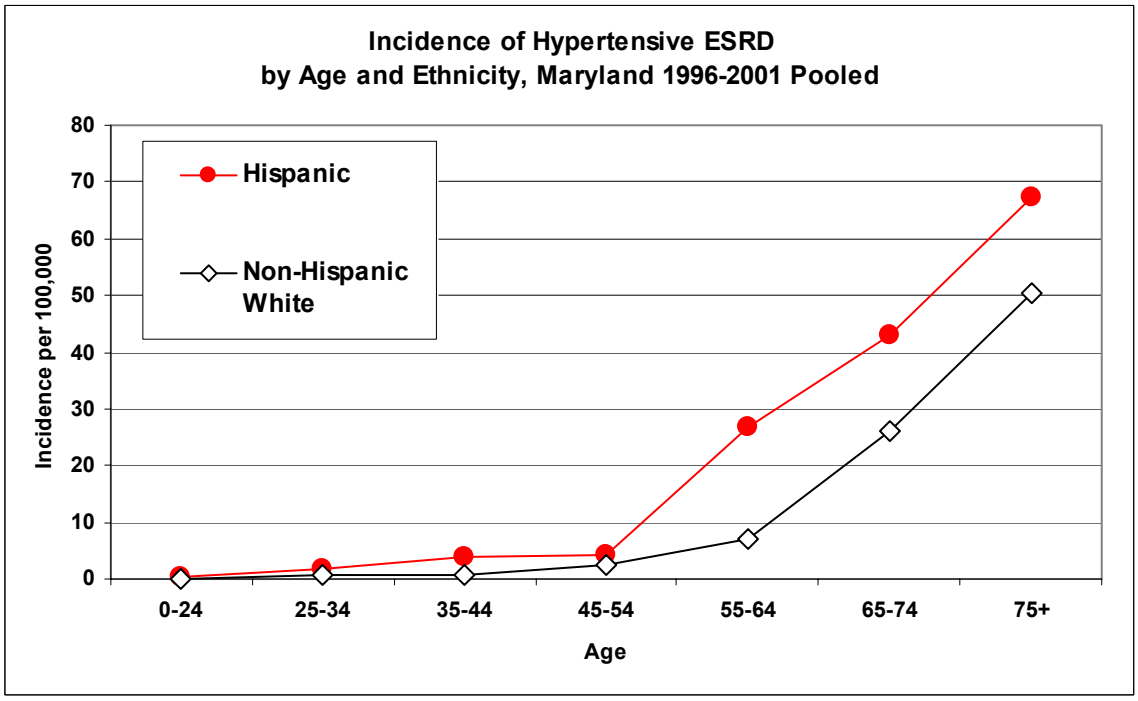
Source: DHMH analysis of U.S. Renal Data System Data [6]

Figure 9. Incidence of Diabetic End-Stage Renal Disease in Maryland, by Ethnicity, 1996-2001 Pooled Data.



Source: DHMH analysis of U.S. Renal Data System Data [6]

Figure 10. Incidence of Hypertensive End-Stage Renal Disease in Maryland, by Ethnicity, 1996-2001 Pooled Data.



Source: DHMH analysis of U.S. Renal Data System Data [6]

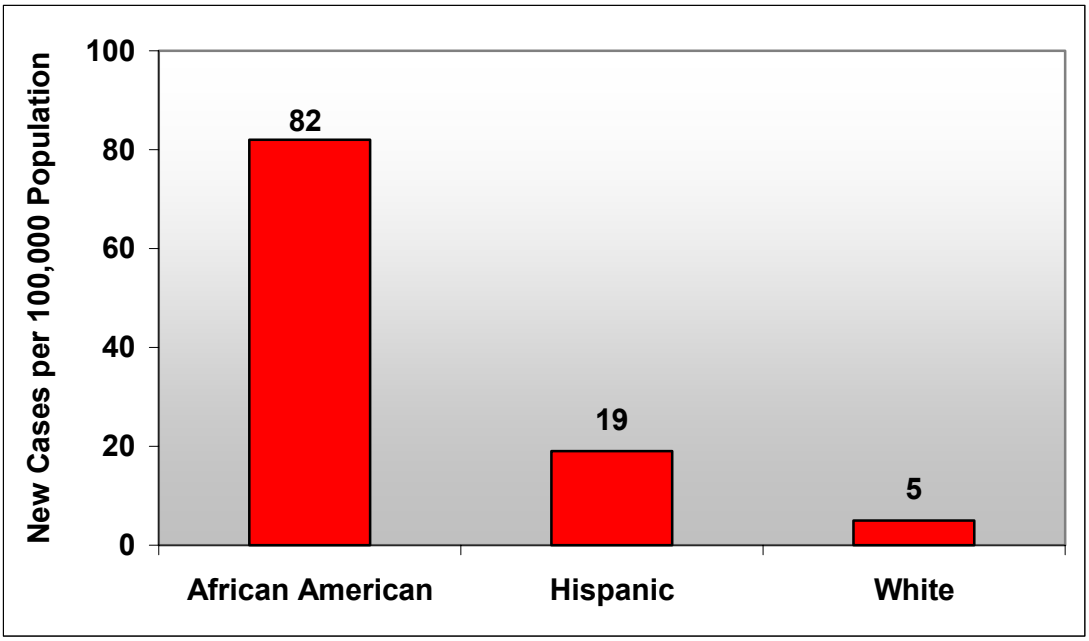
In these analyses, data were pooled over the 11 years for race, and over the six available years for ethnicity, to have enough numbers among the smaller minority groups.

Large disparities in ESRD incidence are seen for African Americans and American Indians. Depending on age group, incidence rates for adults are about two to six times higher for diabetic ESRD in these two minority groups, and from three to 24 times higher for hypertensive ESRD, than for Whites [6]. These incidence ratios far exceed the ratios for the prevalence of diabetes and hypertension, which suggests that these minority groups have hypertension and diabetes that is less well controlled.

ESRD rates for Asians are similar to those for Whites for diabetic ESRD, and 1.5 to five times higher for hypertensive ESRD [6]. Diabetic ESRD rates for Hispanics are 10 to 20 percent higher than for Whites for adults age 55 or older, and hypertensive ESRD rates for Hispanics are 1.5 to five times higher than for Whites [6].

HIV/AIDS. Another condition where striking minority disparities in disease incidence are seen is HIV/AIDS. Figure 11 shows the disparities in the rates of new cases of HIV for African Americans and Hispanics, compared to non-Hispanic Whites.

Figure 11 Maryland HIV Incidence Rate by Race/Ethnicity, 2003.



Source: Maryland 2005 HIV/AIDS Annual Report [7]

The rate of new HIV cases among African Americans is 16 times higher than it is for Whites, and the rate for Hispanics is almost four times higher [7]. Since the disparity in mortality from HIV/AIDS for African Americans is about 13 to one [1], virtually all of the African American mortality disparity in HIV/AIDS is driven by the disparity in the rate of new cases. Only a solution that can address this huge difference in incidence rates will effectively reduce the African American mortality disparity due to HIV/AIDS.

Minority Disparities in Disease Risk Factors

Disparities in the occurrence of disease are driven by disparities in the risk factors for those diseases. These risk factors include environmental exposures, psychosocial stresses, health related behaviors, and genetic differences in susceptibility. There are several risk factors that are important to many chronic diseases: cholesterol, smoking, physical activity, and obesity. The disparities in these risk factors are presented below.

Information on health behaviors is usually obtained from surveys. The BRFSS survey, the source of the information below, is done as a random dialing telephone survey. As such, it does not reach persons without a land line telephone, does not included persons in institutions, and prior to 2007, was not administered in Spanish. These limitations may lead to the survey not reaching the most disadvantaged members of minority populations, and thus the disparities may be larger than shown in the survey data. Also, small sample sizes prevented separate analysis of Asians and American Indians in these age groups.

Cholesterol. Combining data from the 2001 and 2003 BRFSS and examining the same three age groups that were used in the diabetes figures, the proportion of adults ever told by a health professional that they have high cholesterol was similar for African Americans, Hispanics, and non-Hispanic Whites for all ages with one exception: African American Adults age 18-44 were 25 percent less likely that non-Hispanic Whites to have been told they have high cholesterol (statistically significant) [5].

Minority levels of high cholesterol may be underestimated if their rates of testing are lower. The combined 2001 and 2003 BRFSS data reveals that among the survey respondents, African Americans and non-Hispanic Whites were equally likely to have had ever had cholesterol testing, and to have had testing in the last two years [5]. Hispanics were more likely not to have cholesterol testing than non-Hispanic Whites at ages 18-44 (statistically significant) [5].

Smoking. Pooling data from the 2001 to 2004 BRFSS and evaluating smoking in the same three age groups that were used in the diabetes figures shows that the rate of current smoking among African Americans is 20 percent lower at ages 18-44, 25 percent higher at ages 45-64, and almost two times higher at ages 65 or older compared to non-Hispanic Whites (all differences are statistically significant) [5]. Hispanic rates of current smoking, at least in the survey data, are similar to rates among non-Hispanic Whites [5].

Physical Activity. Pooling data from the 2001 to 2004 BRFSS and evaluating physical activity in the same three age groups that were used in the diabetes figures reveals that African American adults were 25 percent to 33 percent less likely (depending on age) to perform moderate physical activity 30 minutes or more, five days a week than were non-Hispanic Whites [5]. Hispanics were 25 percent less likely to meet this goal among adults age 18-44, but equally likely among adults 45-64 [5]. All of these differences are statistically significant. For all races and ages, less than 40 percent of adult met this goal.

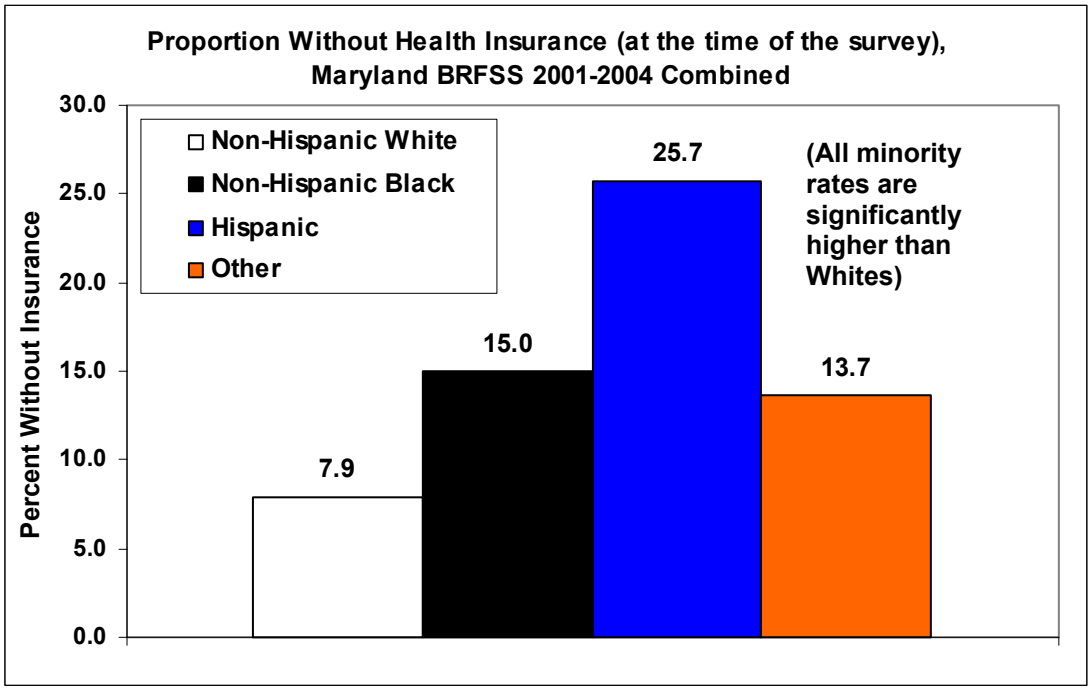
In a similar analysis of the goal of vigorous physical activity 20 minutes or more, three days a week, African American adults were 20 percent less likely to meet this goal than non-Hispanic Whites [5]. Hispanic adults were 20 percent less likely to meet this goal among that age 18-44, but equally likely among adults 45-64 [5]. Once again for all races and ages, less than 40 percent of adults meet this goal.

Obesity. Pooling data from the 2001 to 2004 BRFSS and evaluating obesity in the same three age groups that were used in the diabetes figures reveals that the prevalence of obesity across all age groups is about 1.5 times higher for African Americans than for non-Hispanic Whites (statistically significant) [5]. Obesity rates for Hispanics are similar to non-Hispanic Whites [5].

Minority Disparities in Health Insurance, and in Access to and Utilization of Healthcare

Information on health insurance status is asked in the Maryland BRFSS survey. The rates of uninsurance at the time of the survey are presented in Figure 12. Hispanics have the highest rate of uninsurance by this measure, three times higher than non-Hispanic Whites [5]. African Americans and the group of other races have an uninsurance rate that is about two times higher than non-Hispanic Whites [5].

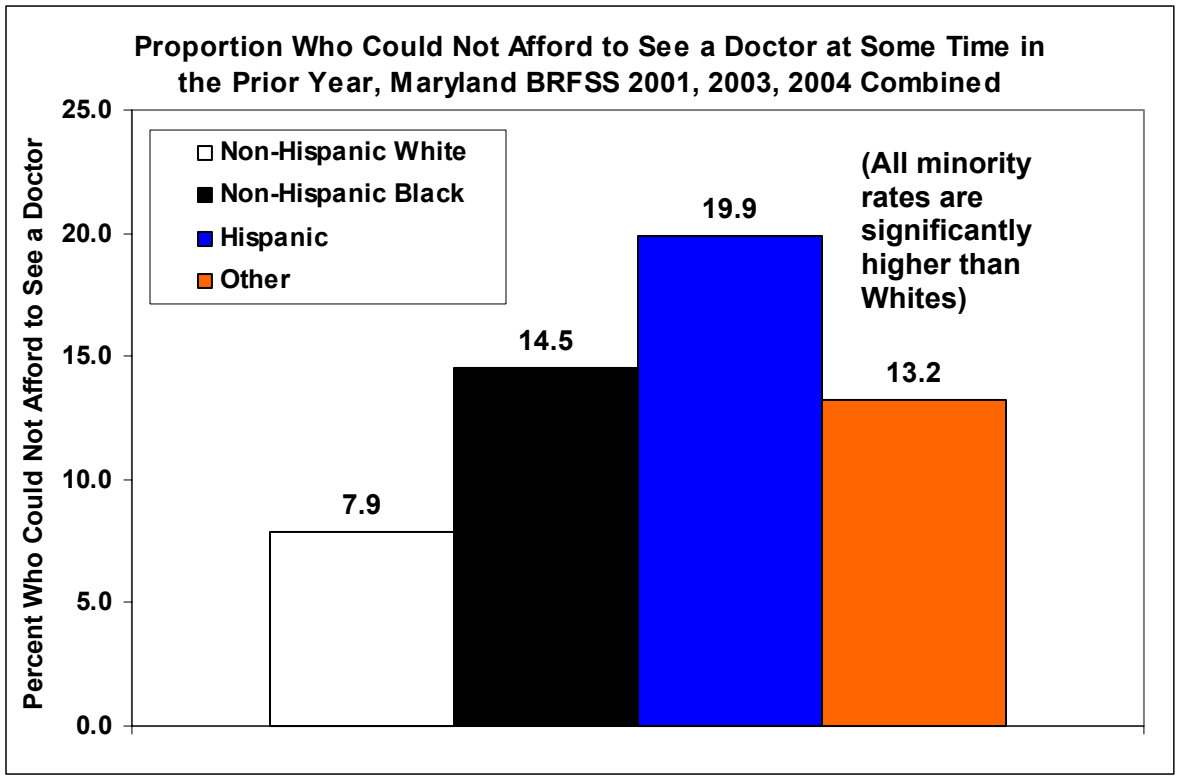
Figure 12. Disparity in Health Insurance, Maryland 2001-2004 Pooled Data.



Source: Pooled data from Maryland BRFSS [5]

In most years, the BRFSS survey also asks if subjects were unable to afford to see a doctor at a time that they needed healthcare during the last year. The results for this analysis in the years 2001, 2003 and 2004 are almost identical to those for uninsured rates (Figure 13) [5]. Hispanics have the highest unable to afford care rate, 2.5 times higher than non-Hispanic Whites [5]. African Americans and the group of other races have an unable to afford care rate that is about 1.75 times higher than non-Hispanic Whites [5].

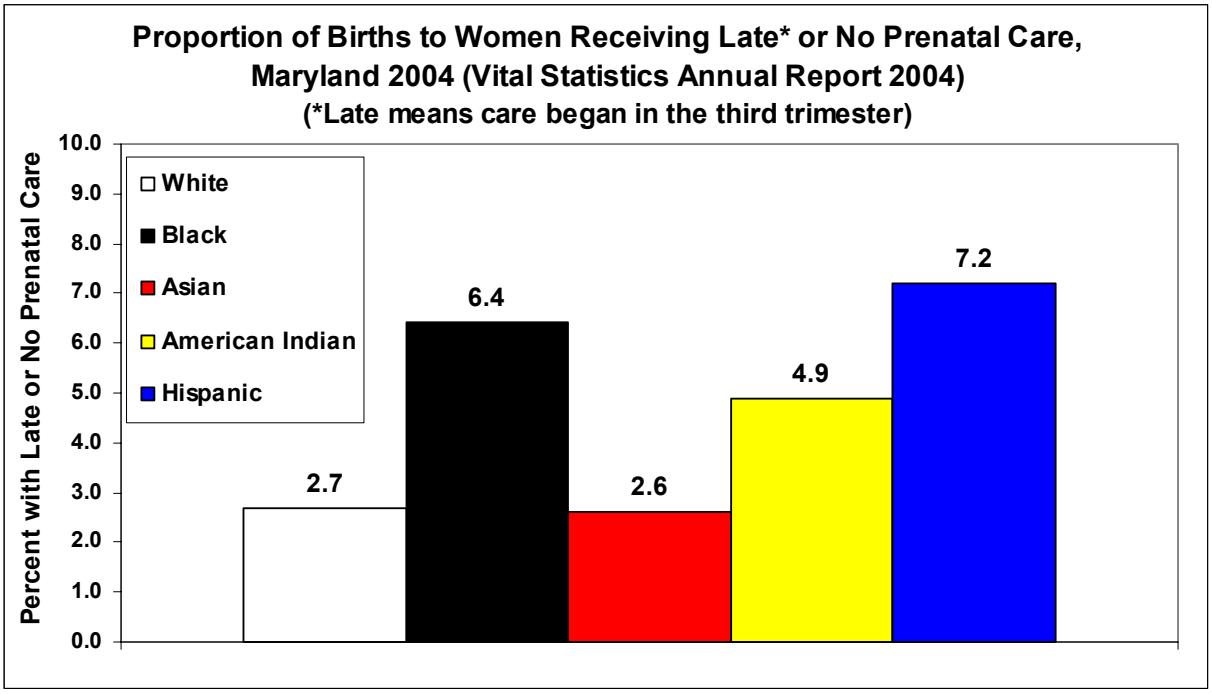
Figure 13. Disparity in Ability to Afford Healthcare, Maryland 2001, 2003 and 2004 Pooled Data



Source: Pooled data from Maryland BRFSS [5]

Vital records data includes information on the timeliness of prenatal care, and this is reported in the Maryland Annual Vital Statistics Reports. Disparities in the percent of pregnant women who receive late or no prenatal care (late prenatal care means care that did not begin until the third trimester) are shown in Figure 14. Compared to Whites, African Americans and Hispanics were about twice as likely, and American Indians about 1.5 times more likely, to receive late or no prenatal care in 2004 [1]. Asian rates of late or no prenatal care were similar to Whites in 2004 [1], but had been slightly higher than Whites in the three previous years.

Figure 14. Disparity in the Timeliness of Prenatal Care.



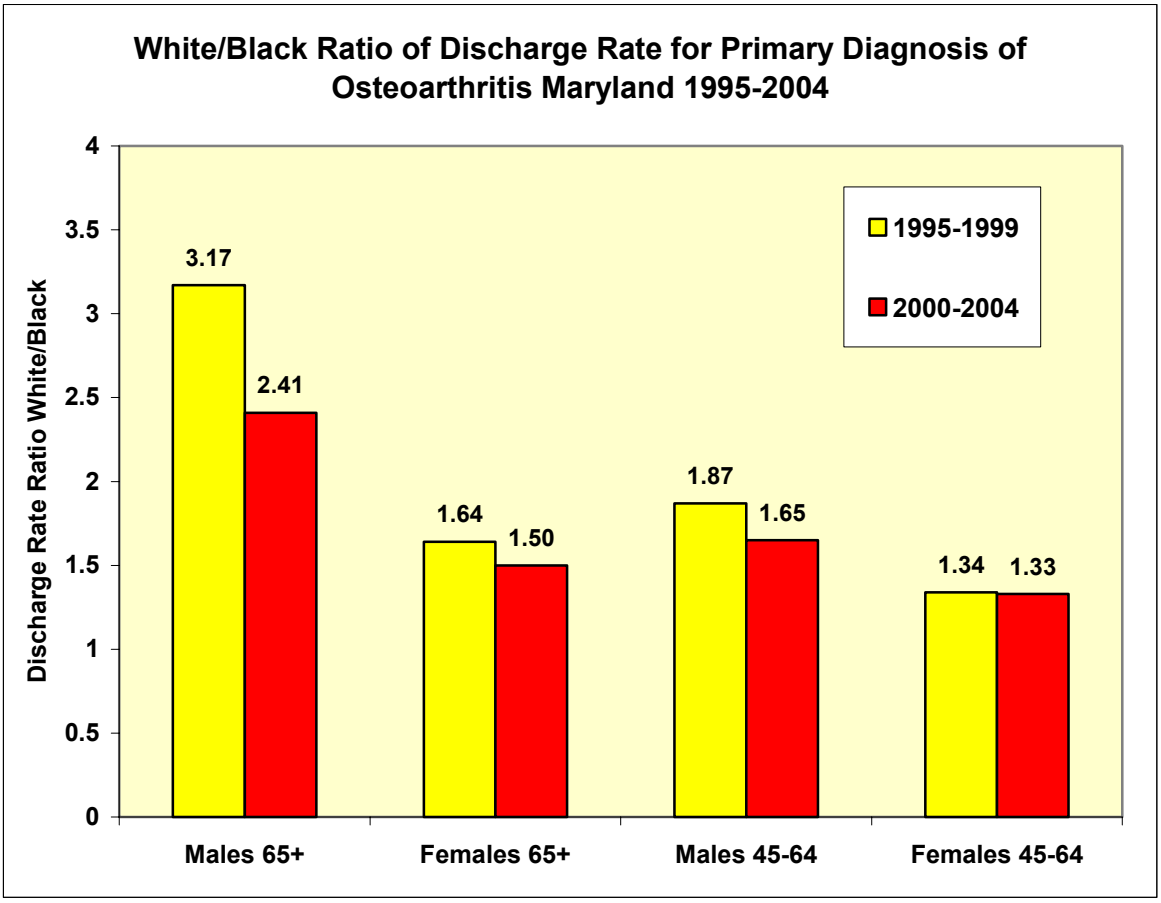
Source: Maryland Annual Vital Statistics Report 2004 [1]

Disparities also exist in the receipt of other beneficial healthcare services. An example of this is the disparity in joint replacement surgery for arthritis. Data from the BRFSS indicate that for adults age 45 or older, the rates of arthritis are similar for African Americans and Whites [5]. In addition, African Americans report more activity limitation due to arthritis than do Whites [5]. Thus, arthritis is equally common between the two races, and perhaps somewhat more severe in African Americans. Therefore, we would expect the need for joint replacement surgery to be similar for the two races.

Discharge data from the Maryland Health Services Cost Review Commission indicate that African Americans age 45 or older are less likely than Whites to get joint replacement surgery [8]. This is shown in Figure 15. The figure displays the disparity in the rate of hospital admissions (discharges) for a diagnosis of osteoarthritis, the most common form of arthritis (chart shows how many times higher the White rate of admissions is compared to African Americans). Since more than 90 percent of these admissions are for a knee or hip joint replacement [8], these ratios also represent the disparity in the use of joint replacement surgery.

It is notable that the disparity is particularly large for males age 65 or older, where Whites were three time more likely to have this surgery in 1995 to 1999, and 2.4 times more likely in 2000 to 2004 [8]. Figure 15 shows that the magnitude of disparities may be different for different age groups or genders, and it does show that for most age-gender groups, some progress has been made in reducing this disparity.

Figure 15. Disparity in Hospital Admissions for Osteoarthritis (which represents disparity in joint replacement surgery)



Source: DHMH analysis of Maryland HSCRC discharge data [8]

Comparing Disease Occurrence to Disease Consequences

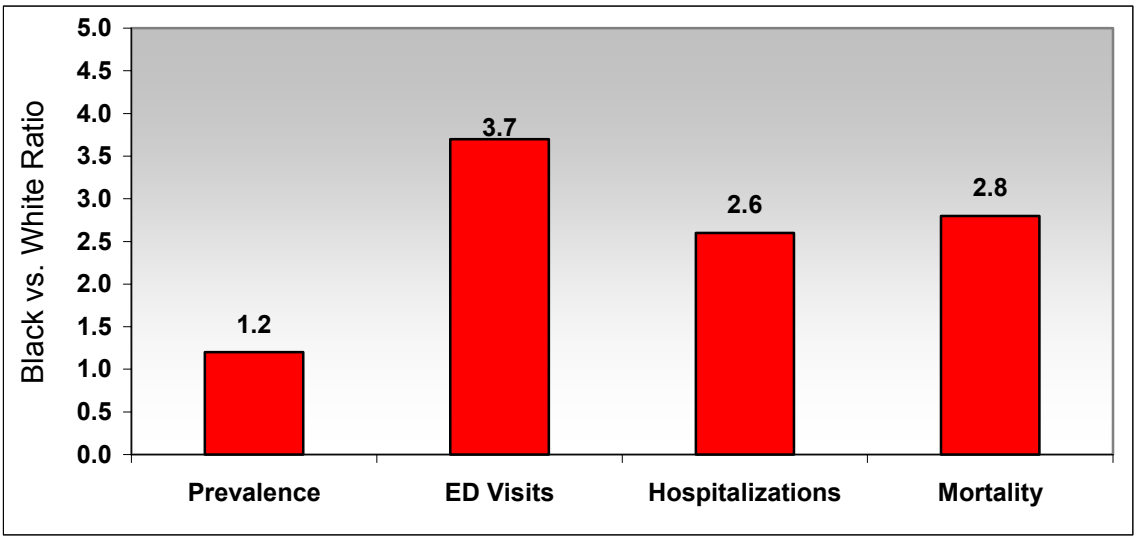
One approach to evaluating health disparities data that helps to target interventions is to compare the disparity in the incidence of a disease to the disparity in the consequences of the disease: complications, disability, healthcare utilization, and mortality.

Considering HIV/AIDS, the 2003 rate of new cases of HIV was 16 times higher for African Americans than for Whites [7], and the age-adjusted mortality from HIV/AIDS in 2004 was 13 times higher for African Americans [1]. This is an example where the disparity in the adverse outcome, in this case mortality, is driven primarily by the disparity in the rate of new cases. Even if access, quality of care, and resultant treatment success were equal between African Americans and Whites, as long as double-digit disparity ratios in new cases exist, double-digit disparities in mortality will persist. Eliminating this mortality disparity will require finding a solution to the disparity in the rate of new cases.

In diabetes, the data showed that for 2001 to 2004 combined, the percent of African Americans with diagnosed diabetes was about twice as high as that percentage among non-Hispanic Whites [5]. The data on ESRD from 1991 to 2001 combined showed that new cases of ESRD were two to six times higher (depending on age) for African Americans than for Whites [6]. This is an example where the disparity in the adverse outcome is about equally due to disparity in the prevalence of the disease, and to disparity in successful management of the disease. Solving either the prevalence disparity or the management disparity alone will still leave about a two-fold disparity in new cases of ESRD. To eliminate the disparity in ESRD, about equal effort toward disparities in disease occurrence and disparities in disease management is required.

Asthma in adults is an example where the disparities in consequences are primarily a result of the disparity in disease management. Data from the DHMH report "Asthma in Maryland 2004" are presented in Figure 16 [9]. The prevalence of asthma, from the Maryland BRFSS, is 1.2 times higher for African Americans that for Whites. Based on that, it might be expected that African American adults experience 1.2 times as many asthma emergency department visits, asthma hospitalizations, and asthma deaths. However, African Americans experience 3.7 times as many asthma emergency visits, 2.6 times as many asthma hospitalizations, and 2.8 times as many asthma deaths [9]. The disparity in these asthma consequences indicates that African Americans experience less treatment success in managing asthma. Treatment success for asthma depends on access to care, quality of provider treatment planning, and the ability of patients to carry out their treatment plan at home (understanding of plan, affordability of medications and devices). It also depends on the ability to remove asthma triggers from the patient's environment. Individual differences in asthma severity and in patient responsiveness to or side effects from medications also influence treatment success. Elimination of the disparities in asthma outcomes will only occur when the disparities in asthma treatment success are eliminated.

Figure 16 African American vs. White Disparity Ratios for Adults with Asthma, Maryland 1999-2003



Source: Asthma in Maryland 2004 [9]

There are more areas where minority health disparities are likely to exist in Maryland than can be included in this document. The Office of Minority Health and Health Disparities is in the process of assembling available data to delineate minority health disparities that may exist in Maryland in the areas of Mental Health, Substance Abuse, Disabilities, Oral Health, Environmental Health, and Infectious Disease.

Success in Reducing Cancer Mortality Disparities in Maryland

Tobacco settlement funds have been used in Maryland to implement a Cancer Control Program. One goal of the program was to target minority populations to reduce their cancer health disparities. Beginning in Fiscal year 2000, funds were distributed to each local health department and to minority organizations throughout the state. The health departments and the minority groups were charged with working together to reach all populations with a special emphasis on reaching minorities. They focused on awareness and screening and in fiscal year 2006, 67 percent of the nearly 8,000 persons screened were minorities.

In the five years since the inception of the targeted efforts within the CRFP to reduce minority disparities in cancer, the difference between the age-adjusted cancer mortality rate for African Americans and Whites has been cut in half. This is illustrated in Figure 17. From 2000 to 2005, the cancer mortality rate for Whites decreased by eight percent, while over the same period, the cancer mortality rate for African Americans decreased by 16 percent. This resulted in a 51 percent decrease in the difference between the mortality rates, from a difference of 44 per 100, 000 in 2000 to 22 per 100,000 in 2005. The application of similar targeted disparity reduction efforts to the other conditions where health disparities exist in Maryland could result in similar reductions in those health disparities.

Figure 17. Reduction in the Cancer Mortality Disparity for African Americans in Maryland, 2000-2005

Cancer Mortaltity Rates, Rate Differences, and Percent Change, By White or Black Race, Maryland 2000 and 2005 (rates are age-adjusted rates per 100,000)

	2000	2005	Percent Decrease
Black Cancer Mortality	246.0	207.7	15.6%
White Cancer Mortality	201.6	185.7	7.9%
Mortality Difference	44.4	22.0	50.5%

Source: Maryland Vital Statistics Annual Report 2005 [1]

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Maryland Department of Health and Mental Hygiene
Minority Health and Health Disparities Website

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Vision:

The Maryland Department of Health and Mental Hygiene envisions a state in which health care services are organized and delivered in a manner designed to eliminate health disparities among its ethnic and racial populations, thereby leading the way to a Healthy Maryland in the New Millennium.

Minority Health and Health Disparities
Maryland Department of Health & Mental Hygiene

Mission:

In fulfillment of the Department's mission to promote the health of all Maryland citizens, the Health Disparities Initiative shall focus the Department's resources on eliminating **health disparities**, partner with statewide organizations in developing policies and implementing programs and monitor and report the progress to elected officials and the public. The target ethnic/racial groups shall include African Americans, Hispanic/Latino Americans, Asian Americans and Native Americans.

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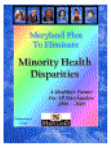


Maryland Plan to Eliminate Minority Health Disparities, Preliminary Copy

Click Here to download a copy of the Plan

Click here to download a Fact Sheet of the Plan

December 2006

The Office of Minority Health and Health Disparities is pleased to announce the release of the **Maryland Plan to Eliminate Minority Health Disparities**, ***Preliminary Copy***.

The purpose of the Plan is to aid Marylanders in charting a course that will ensure that quality health services are delivered to every person in every jurisdiction of the state.

Eliminating minority health disparities in Maryland is an on-going process that calls for a cross section of providers, consumers, and communities to work together, pooling their efforts. This Plan is a work-in-progress and is not exhaustive in its present form. We look forward to receiving your comments and suggestions. Feel free to contact us by any of the methods listed below or use the Feedback Form found in the Plan on page 73 of the Plan.

Our sincere thanks and appreciation go to the many individuals who contributed to the development of this Plan.

Workforce Diversity Initiative

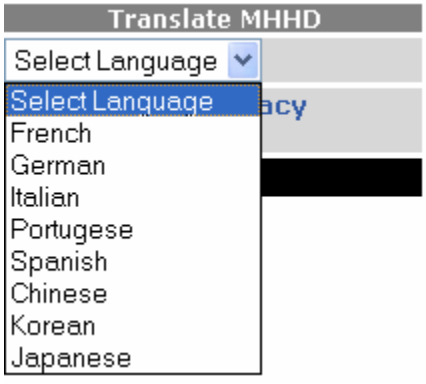
In 2005, the Maryland Office of Minority Health and Health Disparities received a five-year grant from the federal Office of Minority Health as part of the **State Partnership Grant Program.** The State Partnership Grant Program seeks to facilitate the improvement of minority health and elimination of health disparities. For more information on the State Partnership Grant Program and the state grantees, please visit http://www.omhrc.gov/templates/content.aspx?ID=3166.

The Maryland Office of Minority Health and Health Disparities' new grant initiative targets two areas: (1) diversifying matriculation from health professional schools; and (2) implementing a comprehensive evaluation program aiming to achieve system change in the Department of Health and Mental Hygiene to increase the focus by the state and local health departments on reducing health disparities.

The Workforce Diversity Initiative activities focus on:

- Developing partnerships with health professions schools
- Collaborating on issues of recruitment; data collection and monitoring and cultural competency training
- Developing and conducting on-going awareness campaign
- Serving as a clearinghouse for national and state-based resources

For questions relating to the Workforce Diversity Initiative at MHHD, or to alert us to other exciting news on Workforce Diversity please contact our office.



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